

**BEAVER COUNTY
SUPERVISOR'S REPORT OF EMPLOYEE INJURY OR ACCIDENT**

Employee's
Name _____ **Department** _____

Location of
Incident _____

Date of Incident _____ **Time** _____ **Date** _____
Reported _____

What shift was employee working? _____

To Whom Was Incident
Reported _____

Description of Injury (be specific-name any objects or substances involved) _____

Part(s) of Body
Injured _____

Name of Witness _____

Was There Equipment Involved? If so, please explain _____

Was Accident Caused by an Unsafe Act? If so, please explain _____

Was Accident Caused by an Unsafe Condition? If so, please explain _____

(Please complete both sides of this form).

What Could Management Have Done to Prevent the Incident? _____

What Could Employee Have Done to Prevent the Incident? _____

Does Injury Concur With Employee's Report? _____

Was Medical or Emergency Treatment Necessary? Yes _____ No _____

Type of Medical Treatment Provided (Doctor, First Aid, Ambulance to Hospital, _____

Attending Physician (Name and Address _____

Lost Time From Work (estimated)

_____ days _____ hours _____ none _____

**Any Additional
Information** _____

***Prepared**

By _____ **Title** _____

***Supervisor's signature is verification that the validity and completeness of the above statements have been checked.**

Date _____